State of Delaware

The Department of Services for Children, Youth and Their Families

Division of Prevention & Behavioral Health Services

"Integrating prevention, early intervention and mental health to enhance services for children & families"

Intensive Family Consultation (IFC) Referral

Child/ Family Member referred:

CHILD: _____ DOB:_____ SCHOOL:/GRADE _____

Date of Referral: _____ Referral Source Name:_____

PARENT/LEGAL GUARDIAN ***(IF APPLICABLE):*** _____ TELEPHONE NUMBER: _____

ADDRESS: _____

REASON FOR REFERRAL: *Please check all that apply*

- ☐ Family Stressors
- ☐ Family Conflict
- ☐ Home Concerns (homelessness, etc. specify below)
- ☐ Peer Conflict/Interpersonal Problems/Bullying
- ☐ Parent/Child conflict
- ☐ Trauma
- ☐ Verbal Aggression, Physical Aggression or Negative Conduct
- ☐ Other-Describe:

Which reason above is the family's primary concern?

_____

Please provide a brief description of the concerns prompting this referral:

_____

_____

Has the Parent/Guardian been made aware of the IFC referral? ☐ Yes ☐ No

Does the referral source want to be made aware of the outcome? ☐ Yes ☐ No

Referral Source Information:

Name: _____ Role w/ Family: _____Phone #: _____

Email:_____

Signature:_____

Mobile Crisis Service is available 24 hours/day, 7 days/week

1-800-969 HELP (4357) Statewide

Family Household Information:

Please list all children in the home:

Name	Gender	DOB	Race
_____	☐ M ☐ F	_____	_____
_____	☐ M ☐ F	_____	_____
_____	☐ M ☐ F	_____	_____
_____	☐ M ☐ F	_____	_____
_____	☐ M ☐ F	_____	_____

Please list all adults in the home:

Name	Gender	DOB	Race	Relationship to Child:
_____	☐ M ☐ F	_____	_____	_____
_____	☐ M ☐ F	_____	_____	_____
_____	☐ M ☐ F	_____	_____	_____
_____	☐ M ☐ F	_____	_____	_____
_____	☐ M ☐ F	_____	_____	_____

Additional Information:

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Delaware Youth and Family Center
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